Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. JAMES KEVIN HORN

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-14-0693-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was processed and CPT code 20690 was underpaid."

Amount in Dispute: $24.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is not a network claim…Although the services were provided at an inpatient facility, these are for the physician's charges and were billed on a CMS 1500. The stipulation for payment at fee schedule regardless of billed charge does not apply and reimbursement was appropriate."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2013	CPT Code 20690-RT Ankle Surgery	$24.57	$24.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 214-No code description given.
   - U693-By clinical practice standards, this procedure is incidental to the related primary procedure billed.
   - 45- Charges exceed your contracted/ legislated fee arrangement.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the allowance for CPT code 20690-RT included in the allowance of another procedure performed on the disputed date of service?
2. Does the submitted documentation support a contractual agreement issue exist in this dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. On the initial explanation of benefits, the respondent denied reimbursement for code 20690 based upon reason code "U693". Upon reconsideration this denial was not maintained and payment of $582.20 was made for code 20690.
2. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO DISCOUNT" amount on the submitted explanation of benefits denotes a "N/A" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable division rules and guidelines.
3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2013 DWC conversion factor for this service is 69.43.

   The Medicare Conversion Factor is 34.023

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77521, which is located in Baytown, Texas therefore, the Medicare participating amount is based on locality "Houston, Texas".

   The Medicare participating amount for code 20690 is $594.67.

   Using the above formula, the MAR is $1,213.53; however, this code is subject to multiple procedure discounting resulting in $606.77; The respondent paid $582.20. The difference between amount paid and MAR is $24.57, this amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $24.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $24.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		01/09/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.